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April 8, 2010

MEMORANDUM

TO:
- Legislative Oversight Committee Members
- Local CFAC Chairs
- NC Council of Community Programs
- County Managers
- State Facility Directors
- LME Board Chairs
- Advocacy Organizations
- MH/DD/SAS Stakeholder Organizations
- Commission for MH/DD/SAS
- State CFAC
- NC Assoc. of County Commissioners
- County Board Chairs
- LME Directors
- DHHS Division Directors
- Provider Organizations
- NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray

Leza Wainwright

SUBJECT: Implementation Update #71

- TCM for Individuals with DD
- Annual Auth. for Non-Waiver TCM/DD
- 1915 (b)(c) Waiver/RFA Update
- CABHA Updates
- Merger, Acquisitions, and CHOW
- IIH and CST Update
- Rate Reduction Effective Date for CST
- Child and Adolescent Day Treatment
- Day Treatment & IIH Training & Availability
- Peer Support Service
- Update on SPAs
- Clarification on Provisionally Licensed Billing
- Re-Endorsement Clarification
- Online Correction of Unable to Process Requests
- Reporting Fraud, Waste, and Program Abuse

Targeted Case Management Services (TCM) for Individuals with Developmental Disabilities

The Medicaid State Plan Amendment for *Targeted Case Management (TCM) Services for Individuals with Developmental Disabilities* was recently approved by the Centers for Medicaid and Medicare (CMS). The implementation of the approved TCM State Plan Amendment (SPA) is scheduled for July 1, 2010. Attached is a copy of the State Plan Amendment.

The approved TCM SPA contains the basic case management functions similar to the policy in the *July 2005 Medicaid Special Bulletin* under the title of *Targeted Case Management for Mentally Retarded/Developmentally Disabled (MR/DD) Individuals*, with the addition of specific required training. The TCM policy requires each provider to ensure that each case manager hired on or after July 1, 2010 receives **20 hours of training related**

to case management functions: Assessment, Service Plan (Person Centered Plan – PCP) Development, Referral, and Monitoring, within the first 90 days of hire.

Previously case managers were required to receive nine hours of training, six hours of Person Centered Thinking and three hours of Person Centered Planning Elements, as detailed in Implementation Update #36. That requirement is still in effect and that training may be used to count toward the required 20 hours of training. The additional 11 hours of training required for case managers hired on or after July 1, 2010 must be related to case management functions (Assessment, Service Plan Development, Referral, and Monitoring). The training must occur within the first 90 days of hire.

Transition Requirements for Providers of TCM
Effective July 1, 2010 the Division of Medical Assistance (DMA) is requiring all targeted case management provider agencies to be directly enrolled to provide Medicaid reimbursable *Targeted Case Management (TCM) Services for Individuals with Developmental Disabilities.* Attached are two documents related to the required processes: *Transition Requirements: Targeted Case Management Services for Individuals with Developmental Disabilities* and *TCM Letter of Attestation*.

Computer Sciences Corporation (CSC) will begin accepting enrollment applications effective May 1, 2010. The local management entities (LME) will have the ability to continue to bill on behalf of providers until December 31, 2010 to enable adequate time for providers to attain notification of direct enrollment. Existing providers **must** complete the Medicaid provider enrollment process to request direct enrollment by June 30, 2010. Providers of TCM services will receive one provider number for TCM services.

For Existing TCM Providers
For existing providers of TCM services, i.e. providers currently providing TCM and billing Medicaid for those services through an LME, the endorsement process will be completed through the use of the signed Letter of Attestation. Existing providers of TCM are required to sign the attached *TCM Letter of Attestation* indicating compliance to the new TCM policy. The provider sends the original signed *TCM Letter of Attestation* to the LME where the provider's corporate office is located and a copy to all LMEs where the provider has a signed MOA and/or contract. Upon receipt of the original signed TCM Letter of Attestation, the LME where the provider's corporate office is located will complete a notification of endorsement action (NEA) letter and send to the provider agency. The provider agency will submit the signed TCM Letter of Attestation, the NEA letter and a completed Medicaid Provider Enrollment Application to obtain a Medicaid provider billing number (http://www.nctracks.nc.gov/provider/providerEnrollment/).

Upon receipt of the provider number, the case management provider will submit a Provider Change Request form found on the link below to ValueOptions requesting a change of all current, valid TCM service authorizations from the LME's provider number to the TCM agency's new provider number. ValueOptions will update the current authorization to include the agency's provider number.
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The LME (where the provider's corporate office is located) is required to monitor the provider's compliance to the Medicaid State Plan Amendment for ***Targeted Case Management Services for Individuals with Developmental Disabilities*** based on the established monitoring and oversight protocol as defined in the ***Guide to Standardized Administration of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) Frequency and Extent of Monitoring Tool and the Provider Monitoring Tool for Local Management Entities.***

New TCM Providers
Any agency that has not previously delivered TCM services that now wishes to begin delivering that service must complete endorsement and enrollment per the Department of Health and Human Services (DHHS) *Policy and Procedures for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA Services.*

The LME completes endorsement of new providers per the DHHS *Policy and Procedures for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA Services.* **LMEs will not begin accepting applications for endorsement from new TCM providers until May 1, 2010.**

Transition to Annual Authorization for Non-Waiver TCM/DD Services

Effective May 1, 2010, all requests for non-waiver, Medicaid-funded targeted case management services for developmental disabilities will be authorized on an annual schedule rather than the current process of quarterly authorizations. The annual schedule is based on the recipient's birth month. The effective date of the annual authorization period will be the first day of the month following the recipient's birth month and the end of the authorization period will be the last day of the recipient's birth month. **NOTE**: State-funded TCM services for individuals with developmental disabilities must follow all of the requirements of the Medicaid definition and must be reimbursed at the Medicaid rate, but the authorization period will be as determined by each LME's benefit plan.

Example 1

If the recipient's birthday is in June, the annual authorization period will be July 1, 2010, through June 30, 2011.

Any request submitted to ValueOptions on, or after, May 1, 2010, will be authorized through the last day of the recipient's birth month.

Example 2

A request with a start date of May 1, 2010, with the recipient's birth month of November, will have an authorization period of May 1 through November 30, 2010.

Requests received by ValueOptions prior to May 1, 2010, will be authorized for 90 days. **Prior to the end of the 90-day period, the case manager is to submit a request with an end date of the last day of the recipient's birth month.**

Example 3

A request with a start date of April 1, 2010, with the recipient's birth month of November will have an authorization period of April 1, 2010, through June 30, 2010. The case manager will then submit a request, prior to June 30, 2010, with a start date of July 1, 2010, and an end date of November 30, 2010.

1915 (b)(c) Waiver/RFA Update

The bidders conference announced in Special Implementation Bulletin #69 was held on March 4, 2010. Questions and answers from the bidders conference are now posted on both the DMH/DD/SAS and DMA waiver web pages found at the following links:

- DMH/DD/SAS - http://www.ncdhhs.gov/mhddsas/waiver/index.htm
- DMA - http://www.ncdhhs.gov/dma/lme/MHWaiver.htm

Please note that neither DMH/DD/SAS nor DMA can answer any further questions regarding the request for applications (RFA) process as the RFA stipulates the question and answer period is officially closed. This includes any questions from stakeholders (consumers or providers) about potential LME RFA activities or application submissions. However, e-mail addresses can be accessed on the waiver web pages for input and/or comments from stakeholders.

LMEs are to submit applications by April 14th; both Divisions will then begin the formal review of applications. The review process will include a desk review and an on-site review. These review processes will involve staff from both DMH/DD/SAS and DMA, consumers and family members, and staff from Mercer Human Services Consulting, a state contractor. The review process will occur during the months of April, May, and June. A public announcement identifying the selected LME(s) will be made in July 2010 with a tentative start date set for January 2011.

DHHS will continue to engage stakeholders in communications about 1915 b/c waivers at the state level. To assist in keeping stakeholders informed, the waiver presentation presented by Mike Watson, DHHS Assistant Secretary, to the Legislative Oversight Committee on March 10, 2010 has been posted to the waiver websites identified above. The goal is one success at a time, creating a vision of, **"Responsible Change to Achieve Easy Access, Better Quality, and Personal Outcomes."**

Critical Access Behavioral Health Agency Updates

There have been on-going updates made to the Critical Access Behavioral Health Agency (CABHA) policy; these can now be found on the DMH/DD/SAS CABHA web page:

http://www.ncdhhs.gov/mhddsas/cabha/index.htm. There is also a weekly update posted each Monday that identifies the status of those agencies that have submitted a Letter of Attestation for CABHA certification. Please note, per Implementation Update #70, attestation letters received on the old form will not be accepted. The current attestation letter can be accessed on the DMH/DD/SAS CABHA webpage noted above.

The descriptions of the Medical Director, Clinical Director, and the Quality Management/Training Director have been updated and are attached to this Implementation Update. The Desk Review Tool and the Verification Tool have also been revised to match the updated position descriptions. CABHA Letters of Attestation received by DMH/DD/SAS and postmarked April 15th or later will be reviewed according to the position descriptions attached. CABHA Letters of Attestation postmarked prior to April 15, 2010 will be reviewed using the original position responsibilities outlined in Implementation Updates #63, #64, #66, and #68. All providers seeking CABHA certification will need to come into compliance with the updated position descriptions by April 30, 2010.

DHHS is engaged in conversations with CMS regarding an extension for the final implementation date for CABHA agencies. DHHS has asked to begin CABHA implementation effective July 1 but to permit existing providers of Community Support Team (CST), Intensive In-Home (IIH) and/or Day Treatment to have until December 31, 2010 to achieve CABHA status or transition consumers from the service. DHHS is also engaged in conversations with CMS regarding whether or not providers may subcontract with one another in the delivery of CABHA services. At this time, we do not have a formal response from CMS on these issues. While we are hopeful for a positive response to our request, any agency that provides CST, IIH, or Day Treatment that has not submitted a letter of attestation by April 1, 2010 should develop a plan for the transition of consumers to ensure a successful transition by June 30, 2010, should CMS deny our request.

CABHA Medical Director – Small Providers

In response to concerns raised by small providers, DHHS has agreed to one additional change to the CABHA Medical Director requirements. A small provider, defined as a provider that serves 375 or fewer consumers in mental health or substance abuse services, may employ a single physician who meets the credentials outlined in the CABHA policy to serve as the agency's Medical Director for a minimum of eight (8) hours/week. Those eight (8) hours must be devoted to Medical Director functions; no portion of the eight (8) hours may be spent in direct, billable service. The eight (8) hours may be served in a single day or on multiple days throughout the week. Medication management is one of the core services that CABHA's must provide; small agencies with an eight (8) hour medical director must still ensure that the consumers they serve have access to medication management and direct physician services, but those services may be provided by physicians other than the Medical Director.

With this change, an agency serving 375 or fewer consumers must have a minimum of an eight (8) hour medical director, agencies serving between 376 and 749 consumers must have a minimum one-half time medical director, and agencies serving 750 consumers or more must have a minimum of one FTE medical director. All other requirements of the CABHA medical director remain unchanged.

CABHA Medical Director Exception Process

Implementation Updates #68 and #70 detailed the exception process that must be followed for physicians that require specific approval from the Secretary of the Department of Health and Human Services to be approved as Medical Directors for CABHAs. Agencies wishing to request an exception under this policy should submit the required documents noted in Implementation Update #70 *along with a specific written request stating that the provider is requesting an exception as part of the provider's attestation letter submission package*. If sufficient information is provided to support the written exception request, the request will be submitted to a committee of DHHS representatives for processing as noted in Implementation Update #70.

CABHA Questions

In order to ensure that providers', LMEs, and other stakeholders' questions are answered promptly and correctly, all questions regarding CABHA certification, attestation letters, medical director requirements, etc. should be sent via electronic mail to DMH/DD/SAS at the following address: contact.dmh.lme@dhhs.nc.gov. Due to the volume of activity, electronic mail submissions will receive priority and will receive a response more promptly than telephone inquiries.

Merger, Acquisitions and Change of Ownership

We have received significant feedback regarding the information outlined in Implementation Update #70 regarding how agency change of ownership, mergers or acquisitions would impact Medicaid enrollment, national accreditation, and endorsement. We understand that the language in that section has caused concerns among provider agencies in terms of the liability that the new or acquiring provider might incur. We recognize the concerns and are in conversations with legal council to develop revised language. Revised guidance will be issued as quickly as possible, but no later than the May Implementation Update. We regret the concerns that this issue has caused.

Intensive In-Home Services/Community Support Team Update

The revised definitions for Intensive In-Home Services (IIH) and Community Support Team (CST) have been posted in Clinical Coverage policy 8A on DMA's website at http://www.dhhs.state.nc.us/dma/mp/index.htm. These policies go into effect on July 1, 2010. Current providers of IIH and CST must comply with all changes in the definition by July 1, 2010, with the exception of the training requirements. The training timelines for current providers of IIH and CST begin on the effective date of this policy, July 1, 2010. IIH and CST providers are strongly encouraged to begin training staff as soon as possible. Endorsement check sheets and directions reflecting the new criteria will be posted to the DMH/DD/SAS endorsement web page, http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm#checksheets, by May 1, 2010 for use July 1, 2010.

All IIH staff shall complete training in the following treatment therapies, practices or modalities:

- Motivational Interviewing,

AND

- Cognitive behavioral therapy, trauma-focused therapy and/or family therapy

All CST staff shall complete training in the following treatment therapies, practices or modalities:

- Motivational Interviewing,

AND

- Cognitive behavioral therapy, trauma focused therapy and/or the Illness Management and Recovery Toolkit.

Based on the comments submitted, the identified trauma focused and family therapies in IIH serve as examples as opposed to a finite list of options. The identified trauma focused therapies in CST also serve as examples as opposed to a finite list of options.

When identifying a practice or model under one of the categories above, the practice or model must be clearly identified as a "treatment" practice or model that addresses the rehabilitative needs of individuals with identified mental health or substance-related disorders. We have heard that some providers are selecting "prevention" practices or models. A "prevention" practice or model is a strategy or approach intended to prevent an undesirable outcome, while a "treatment" practice or model is intended to alter the course of an existing mental health or substance-related disorder (SAMHSA's National Registry of Evidenced Based Program and Practices). Since IIH and CST are treatment services, only treatment practices or models are acceptable.

The Centers for Medicare and Medicaid define rehabilitative (treatment) services as:

- recommended by a physician or other licensed practitioner in order to achieve specific individualized goals and to result in reduction of disability and restoration of the individual to the best possible functional level (e.g., service order);
- designed and coordinated to lead to the goal of maximum reduction of physical or mental disability and restoration to best possible functional level (e.g., PCP goals);
- delivered by a qualified provider (as defined in the state plan - e.g., qualified staff); and
- a restorative service furnished to a person with a functional loss who has a specific rehabilitative goal toward regaining that function, or a service to maintain functioning, but only when necessary to help an individual achieve a rehabilitation goal defined in the rehabilitation plan (e.g., outcomes).

In all cases, all criteria (program, staffing, clinical and other) for the IIH or CST service definitions and all criteria for the chosen practices and models must be followed.

All staff shall be trained in motivational interviewing as well as the other practice(s) or model(s) identified above and chosen by the provider. All training shall be specific to the role and qualifications of each staff member and specific to the population served.

Licensed (inclusive of provisionally licensed individuals working under appropriate supervision) staff shall be trained in and provide the aspects of these practice(s) or model(s) that require licensure, such as individual therapy or other therapeutic interventions falling within the scope of practice of licensed professionals.

Non-licensed staff [qualified professionals, associate professionals, Peer Support Specialists, and paraprofessionals] shall be trained in and provide only the aspects of these practice(s) or model(s) that do not require licensure and are within the scope of their education, training, and expertise.

It is expected that licensed staff will practice within their scope of practice and that non-licensed staff will practice under supervision according to the service definition. It is the responsibility of the licensed supervisor and the CABHA Clinical Director to ensure that the non-licensed staff practice within the scope of their education, training, and expertise and are not providing any services that require licensure.

Rate Reduction Effective Date for Community Support Team Service
The effective date for the following rate decrease is July 1, 2010.

Service Code	Service Description	Service Unit	Current Rate	New Rate
H2015 HT	Community Support Team	per 15 min unit with a five hour per week maximum	15.60	11.80

Fee schedules are available on DMA's website at http://www.ncdhhs.gov/dma/fee/. Providers must always bill their usual and customary charges.

Child and Adolescent Day Treatment
Child and Adolescent Day Treatment went into effect on April 1, 2010. The following are areas of clarification to the definition. The updated definition can be found in Clinical Coverage Policy 8A on DMA's website at http://www.dhhs.state.nc.us/dma/mp/index.htm and the revised endorsement checksheet can be found on the DMH/DD/SAS website, http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm#checksheets.

Memorandum of Agreement (MOA)
The day treatment provider agency shall establish a memorandum of agreement (MOA) among the day treatment provider, the local management entity, and the local education agency (or private or charter school as applicable). In the event that a provider operates a day treatment program and is also a private or charter school, the provider only needs to sign an MOA with the LME. If the day treatment program (which is also a private or charter school) serves children from other LEA(s), private, or charter school(s) then appropriate MOA(s) should be signed with the responsible LEA(s), private, or charter school(s). If the LEA, private or charter school refuses to sign an MOA, the day treatment program will be unable to be reimbursed for any Medicaid or State-funded day treatment services provided. However, at this time DHHS is requesting that LMEs not withdraw endorsements if no MOA is established until DHHS has sufficient time to consult with the Department of Public Instruction and the Centers for Medicare and Medicaid.

Day Treatment Staffing
This service is delivered by the following staff per licensed site:

- One (1) full time program director who meets the requirements specified for a qualified professional (preferably Master's level or a licensed professional) and has a minimum of two years experience in

child and adolescent mental health/substance abuse treatment services who must be actively involved in program development, implementation, and service delivery. This individual may serve as one of the qualified professionals in the day treatment program staffing ratio;

AND

- a minimum of one (1) full time equivalent (FTE) qualified professional (QP), per six children, who has the knowledge, skills, and abilities required by the population and age to be served, who must be actively involved in service delivery. (For example, a program with four recipients needs one FTE QP, a program with seven recipients needs two FTE QPs), and a program with 19 recipients needs 4 FTE QPs.)

AND

- a minimum of one (1) additional FTE (qualified professional, associate professional, or paraprofessional) for every 18 enrolled recipients beginning with the 18th enrolled recipient. (For example, a program with 17 recipients does not need the additional FTE; a program with 21 recipients needs one additional FTE; and a program with 36 recipients needs two additional FTEs.)

AND

- a minimum of a .5 of a full time dedicated licensed professional for every 18 enrolled recipients. This individual must be actively involved in service delivery. A provisionally licensed professional who fills this position must be fully licensed within 30 months from the effective date of this policy. For provisionally licensed professionals hired after the effective date of this policy, the 30-month timeline begins at date of hire. For substance abuse focused programs, the licensed professional (LP) must be a Licensed Clinical Addictions Specialist (LCAS). (For example, a program with 10 recipients needs one .5 LP; a program with 19 recipients needs one full time LP.)

Although the licensed professional is in addition to the program's qualified professional to child ratio, he or she may serve, as needed, as one of the two staff when children are present.

A minimum ratio of one qualified professional to every six children is required to be present, with a minimum of two staff present with children at all times. The exception is when only one child is in the program, in which case only one staff member is required to be present. The staffing configuration must be adequate to anticipate and meet the needs of the recipients receiving this service.

If, for additional staffing purposes, the program includes persons who meet the requirements specified for associate professional or paraprofessional status according to 10A NCAC 27G.0104, supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure requirements of the appropriate discipline.

Clarification of Therapeutic and Educational Activities

The day treatment program staff collaborates with the school and other service providers prior to admission and throughout service duration. The roles of day treatment staff and educational/academic staff are established through the MOA among the day treatment provider, the LME, and the LEA (or private or charter school as applicable). Designation of educational instruction and treatment interventions is determined based on staff function, credentials of staff, the child's person centered plan, and the individual education plan (IEP)/504 plan. Source of staff salary does not necessarily determine educational or treatment determination. Educational instruction is not billable as day treatment. The therapeutic milieu should reflect integrated rehabilitative treatment and educational instruction.

Hours of Operation

This is a day/night service that shall be available year round for a minimum of three hours a day during all days of operation. During the school year, the day treatment program must operate each day that the schools in the local education agency are in operation, and the day treatment operating hours shall cover at least the range of hours that the LEA's, private or charter school's operate (i.e. they must operate during the hours the LEA, private or charter school's operate but may offer other additional hours).

Service Type/Setting

A facility providing day treatment services shall be licensed under 10A NCAC 27G .1400 or 10A NCAC 27G .3700; 10A NCAC 27G .3700 was inadvertently left out of the policy.

Day Treatment and Intensive In-Home Training and Trainers

The Child and Adolescent Day Treatment and Intensive In-Home service definitions have specific requirements (with specified hours of training required) that pertain to an Introduction to System of Care and to Child and Family Team Programs and Practices. Eight (8) hours of total training covering these topics is required for day treatment. Eight (8) hours for Introduction to System of Care and eight (8) hours for Child and Family Team Programs and Practices are required for intensive in-home for a total of sixteen hours.

North Carolina is fortunate to have a variety of trainers available in the state. The System of Care (SOC) coordinators in each LME are knowledgeable about the various training resources available and can be contacted for such information. In many cases, the SOC coordinators are themselves able to train locally on these topics and provide credit. For more information on their availability, you may contact your LME SOC coordinator.

Other resources:

- **The University of North Carolina Greensboro's Center for Youth, Family, and Community Partnerships** has trainers available and conducts ongoing SOC and CFT training periodically. These courses include:
  - *Introduction to Child and Family Teams: A Cross System Training from the Family's Perspective*
  - *Child and Family Teams from the Family's Perspective: Part Two - A Cross Systems Approach to Facilitating Family Driven Meeting*
    - UNCG offers Training of Trainers courses in each of the above courses.
  - For more information on current UNCG course descriptions, registration fees and training dates go to www.uncg.edu/csr/ (under "Child and Family Team Capacity Building")
  - In addition, UNCG trained many of the SOC coordinators and Family Partners to be trainers in the two part Cross System Child and Family Team courses. A list of those approved to train can be found at: http://www.ncdhhs.gov/mhddsas/childandfamily/index-new.htm

- **North Carolina State's Center for Family and Community Engagement** has a number of trainers on staff knowledgeable in the SOC and CFT areas and can be found at: http://www.cfface.org/staff/projectstaff.htm or www.ncswlearn.org
  - A listing of applicable NC State SOC and CFT trainers can also be found at: http://www.ncdhhs.gov/mhddsas/childandfamily/index-new.htm

- **MeckCares**, **a Center for Mental Health Services grantee within the Mecklenburg LME,** offers weekly training on SOC/CFT and related topics that can be accessed at: http://www.charmeck.org/Departments/MeckCARES/Training.htm

Peer Support Services (PSS)

The new Peer Support Services (PSS) definition is still under DHHS review based on public comments. The Centers for Medicare and Medicaid (CMS) are still reviewing this service as an addition to the current approved State Plan.

Update on State Plan Amendments for Peer Support Services, Facility-Based Crisis Services for Children and Adolescents, and Therapeutic Family Services

The Centers for Medicare and Medicaid Services are currently reviewing NC's proposed State Plan Amendments (SPA) for Peer Support Services, Facility-Based Crisis Services for Children and Adolescents, and Therapeutic Family Services. We anticipate that CMS will review the proposed SPA for Mental Health/Substance Abuse Targeted Case Management within the next 30 days.

Extension of Coverage for Provisionally Licensed Providers Billing Outpatient Behavioral Health Services through the Local Management Entity

The March 2010 Medicaid Bulletin and Implementation Update #70 reported on the extension of coverage of provisionally licensed providers delivering outpatient behavioral health services as a reimbursable service under Medicaid and State funds and billed through the LME to June 30, 2011. This bulletin article listed the HCPCS

procedure codes that could be utilized to bill for services delivered by the provisionally licensed individuals. These codes were codes H0001, H0004, and H0005. HCPCS procedure code H0031 was inadvertently omitted and should be added to the above list of procedure codes.

Re-Endorsement Clarification

Implementation Update #54 outlines the procedure for re-endorsement. There has been some confusion regarding the LME's need to complete an onsite review prior to issuing an NEA letter for a three year site/service re-endorsement.

The LME is not required to complete an onsite review prior to issuing an NEA letter for a three year site/service re-endorsement. Since the LME has completed on-going monitoring activities (monitoring reviews, post payment reviews, follow-up on plans of correction, etc.) during the three year endorsement period, it is expected that the ongoing monitoring activities that were completed by the LME will provide enough information about the provider's performance to assist the LME in making the re-endorsement decision. Based upon this information, the LME will make the determination as to the need for an onsite review.

Online Correction of Unable to Process Requests

A new enhancement to the ValueOptions online web portal ProviderConnect will alert providers to requests being returned as Unable to Process. The alert will be a message to a provider's inbox indicating the reason for the return and will allow the provider to quickly modify the request and resubmit, minimizing the potential loss of authorized days of service. Unable to Process letters will continue to be mailed but the online notification will be quicker than the hardcopy letter in the mail. The new enhancement only applies to authorization requests submitted via ProviderConnect. To learn how to submit authorization requests online via ProviderConnect, please visit http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm and register for an upcoming webinar training located in the section titled *Provider Training Opportunities*.

Reporting Fraud, Waste, and Program Abuse

DMA's Program Integrity (PI) section is devoted to carrying out its mission to ensure compliance, efficiency, and accountability within the N.C. Medicaid Program by detecting and preventing fraud, waste, program abuse, and by ensuring that Medicaid dollars are paid appropriately. You are encouraged to report matters involving Medicaid fraud and abuse. If you want to report fraud or abuse, you can remain anonymous. However, sometimes in order to conduct an effective investigation, staff may need to re-contact you. Your name will not be shared with anyone investigated. (In rare cases involving legal proceedings, we may have to reveal who you are.)

To report suspected Medicaid fraud, waste or program abuse by a Medicaid provider:

- Contact DMA by calling the CARE-LINE Information and Referral Service at 1-800-662-7030 (English or Spanish) and ask for the DMA Program Integrity Section; or
- Call DMA's Program Integrity Section directly at 1-877-DMA-TIP1 (1-877-362-8471); or
- Call the State Auditor's Waste Line at 1-800-730-TIPS; or
- Call the Health Care Financing Administration Office of Inspector General's Fraud Line at 1-800-HHS-TIPS; or
- Complete and submit a Medicaid fraud and abuse confidential online complaint form via this link: http://www.ncdhhs.gov/dma/fraud/reportfraudform.htm.

Examples of Medicaid fraud and abuse by Medicaid providers (list is not all-inclusive)

- Medicaid recipient failed to report other insurance when applying for Medicaid
- Non-recipient uses a recipient's Medicaid card with or without recipient's knowledge
- Provider's credentials/qualifications are not accurate
- Provider bills for services that were not rendered
- Provider performs and bills for services not medically necessary
- Provider alters claim forms and recipient records

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

cc: Secretary Lanier M. Cansler
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